Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/02/2012
IRO CASE #:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
TLSO brace including L0464

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic spine surgeon, practicing neurosurgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the claimant does not meet ODG guidelines and medical necessity does not exist for TLSO brace including L0464.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 06/12/12
Utilization review determination dated 04/26/12
Utilization review letter of notification dated 01/27/12
Utilization review determination dated 05/04/12
Utilization review letter of notification dated 05/04/12
Clinical records Dr. dated 10/24/11-04/20/12
MRI lumbar spine 02/01/12
Radiographic report lumbar spine 03/29/12
Utilization review determination dated 01/17/11
Utilization review determination dated 04/26/11
Utilization review determination dated 02/21/12
Utilization review determination dated 02/28/12
Psychiatric evaluation no date
Request for continuity of care D.C. no date

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who was injured on xx/xx/xx. He developed low back pain as result of lifting heavy lumber. He had severe lumbosacral pain with bilateral radiating hip and leg pain worse on left. He underwent lumbar myelogram and MRI which points to L5-S1 disc problems with left lateralizing disc herniation. He had 1 epidural steroid injection, which did not help and has been treated with oral medications. On physical examination he is noted to be 5'6" tall and weigh 180 lbs. He walks with flexed posture. He has fair lumbar musculature tightness. He has tenderness mainly over sciatic outlet and has antalgic gait. Straight leg raise is positive on right. Deep tendon reflexes are 1+ in knees and trace in ankles. He has difficulty with heel and toe standing bilaterally. There is scattered hyperalgesia mainly in distal left S1 dermatome. There is weakness of plantar flexion and dorsiflexion of left foot.

He is noted to have somewhat wide based gait. The claimant was recommended to undergo posterior L5-S1 decompression, fusion and instrumentation. The record includes MRI of lumbar spine dated 02/01/12. This study notes mild central bulging of disc at L3-4, which causes mild encroachment upon the central aspect anterior portion of dural sac. The neural foramina facets are maintained.

At L5-S1 there is asymmetric bulging of disc noted centrally and to left of midline causing mild encroachment upon the central and left anterolateral aspect of dural sac and left neural foramen. Lumbar flexion / extension radiographs were performed on 03/29/12. These studies showed no evidence of acute radiographic abnormality or instability. On 01/17/11 a request was placed for lumbar interbody fusion L5-S1. The reviewing physician Non-certified the request noting the claimant did not meet ODG criteria, and as such, TLSO brace was recommended as medically necessary. A subsequent appeal request was reviewed on 04/26/11. The reviewer non-certified the request for surgical intervention and TLSO brace. There was no evidence of instability and as such the claimant did not meet criteria. On 02/21/12 a new request was submitted for L5-S1 fusion. This was non-certified again noting no evidence of instability. It was noted that the claimant was a smoker and that there is no evidence that the claimant had quit, as well as there was a discussion regarding conservative treatment. The subsequent appeal request was reviewed on 02/28/12. The reviewer non-certified the request and again notes that there is a lack of any significant instability or spondylolisthesis to warrant fusion surgery at this time. A request was placed for a TLSO brace L0464. The initial review was performed on 04/26/12. The reviewer non-certified a request for surgery noting that there is a lack of significant instability or spondylolisthesis to warrant fusion procedure. There is a lack of documentation to support the request for trans-catheter therapy and electrical stimulation. The claimant is again noted to be a smoker. A TLSO brace was non-certified as medically necessary. An appeal request was reviewed for TLSO brace only on 05/04/12. The reviewer non-certified the request noting that the claimant is not a candidate for surgery and that TLSO is only supported in the presence of instability or as a result of spinal fusion surgery.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

This man has chronic low back pain that is radiating to the left lower extremity without evidence of instability. Surgery has been recommended on multiple occasions. The record indicates the claimant has not been approved for surgical intervention, which would be primary indication for this brace. There is no evidence of instability, which would be secondary indication for use of this brace. It is the opinion of the reviewer that the claimant does not meet ODG guidelines and medical necessity does not exist for TLSO brace including L0464.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
[ ] INTERQUAL CRITERIA
[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
[ ] MILLIMAN CARE GUIDELINES
[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES
[ ] TMF SCREENING CRITERIA MANUAL
[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)